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ABSTRACT

Drawing on personal observations and on a study of patient reactions, this paper considers the problem of doctor/patient communication failure in the inner city clinic. It first discusses the role of dialect variation in communication failure, causes of communication failure in the medical interview, factors contributing to doctor/patient communication failure, and dialect and affective response. It then reports on an experiment in which 20 black patients in a Chicago clinic listened to a message that had been tape recorded by three doctors--a local white doctor, a local black doctor, and a foreign doctor--and rated the doctors on 19 personality, competence, and trustworthiness variables. The results reported reveal that the white doctor was perceived the most favorably on 15 of the 19 variables. The paper then provides possible interpretations of the findings based on findings of previous studies and on variables in the three tape recordings; discusses anomalies in the findings; and points to problems involved in attempting to generalize from the findings. It concludes by stressing that miscommunication in inner city clinics is a very real problem and by pointing out the need for doctors, patients, and clinic administrators to make conscious efforts toward improving the situation. (GT)

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DOCTOR-PATIENT COMMUNICATION FAILURE:

The Special Case of the Inner-city Clinic

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INTRODUCTION: DIALECT VARIATION AND COMMUNICATION FAILURE

> Language most shewes a man: speake that I may see thee. It springs out of the most retired, and inmost parts of us, and is the Image of the Parent of it, the mind. No glasse renders a mans forme, or likenesse, so true as his speech.
>
> --Ben Jonson (1)

Most people view language primarily as a mode of communication, though few will deny that language, especially the spoken language, also plays a very large role in how they view themselves and others. The way a person speaks, to a certain degree, can indicate his socio-economic status, regional background, and the people that he identifies with--and in most cases with an amazing degree of accuracy. Similarly, manner of speaking may also allow a person to discriminate those who do not share his life-style because most people try to reflect their socio-economic status, actual or anticipated, and their system of values in their speech. The way a person chooses his words, pronounces them, inflects them, organizes them into sentences, and so on can say a lot about the person, but exactly what it says is entirely dependent upon who is listening. It is this speaker-listener relationship that determines when social dialects are used to the speaker's advantage, or when they become a hindrance to communication. For example, one of the problems faced by many students who speak non-standard dialects of English at home is that their natural manner of speaking appears inadequate to their teachers. Likewise, the manner of speaking encouraged by most educators often intimidates non-standard English speakers--it sounds uppity or pretentious. The dinner table may require the use of one dialect and the college interview another. It is the student who is able to switch from one dialect to another, according to

which is appropriate to his situation and listener, that uses dialect variation as a communication tool: he chooses the dialect that works to his advantage, that best suits his purpose.

Some people aren't so lucky--even though their manner of speaking varies according to their situation, for many non-standard English speakers this conscious choice of a standard or a non-standard dialect doesn't exist. This limitation can cause tremendous difficulties to the speaker when he has to communicate outside of his natural dialect community. He may find that he is sometimes misunderstood because he isn't always capable of communicating well in the dialect appropriate to his circumstances. Such is the case with many working class people, especially those who live in large inner-city communities. Their inability to manipulate their manner of speaking often causes communication problems in school, or when trying to transact business with middle class employers, realty agents, lawyers, and the like. Granted, some people, especially upwardly mobile middle class people consider dialect variation a convenient class indicator and make few attempts to really understand the non-standard speaker--to avoid any identification with a social stratus lower their own they choose not to understand or be familiar with dialects they think middle and upper class people don't speak. Some people, having had little exposure to non-standard dialects, truly have difficulty understanding the non-standard speaker. However, very few speakers who speak a more standard dialect of English ever imagine that they might not be understood by the non-standard speaker; they aren't even aware that the communication problem caused by the speaker's inability to choose the dialect best suited to his listener <u>works both ways</u>. It is often assumed that whereas non-standard dialects are sometimes difficult to understand, everyone understands "correct English".

Unfortunately, this is totally untrue.

Spoken language, then, is one of the best ways man has to express his ideas and feelings, and it also has the added feature of being an indicator of the way other men think and feel. Social dialects, however, complicate matters because when a speaker and listener do not share the same dialect, the language sometimes fails to accurately express their thoughts, feelings and intentions to each other--there is a communication breakdown.

Communication failure due to dialect variation is a common problem, but one of particular concern in medicine. This is because a large part of medicine's success depends on the doctor understanding exactly how the patient feels. Communication failure in the schools can result in feelings of frustration, mis-education, and for some people the failure of the educational system as a whole, but communication failure in medicine can be a life or death issue. This report takes a look at the far-reaching implications of doctor-patient communication failure due to dialect variation in a very special situation: the inner-city medical clinic.

THE MEDICAL INTERVIEW AND COMMUNICATION FAILURE

In the clinic, where ill people are treated on an out-patient basis, the medical interview is extremely important to how symptoms are evaluated and what treatment is prescribed by the doctor. Unlike the specialized private practicioner or the 'family doctor', the clinic doctor may see a certain patient only once, regardless of how many times the patient comes to the clinic for the same problem. Whether the patient is returning to the clininc for further treatment or coming to the clinic for the first time, a large part of the treatment he receives is dependent upon exactly what information the patient chooses to supply about the problem, and how he communicates that information to his doctor. Likewise, what is not said to the doctor, because the patient's confidence and trust in the doctor is inhibited, could cause an incorrect evaluation of the patient's symptoms and, consequently, the improper medical treatment of the patient's illness.

Dr. Roger Shuy recounts an incident he and his associates witnessed in a clinic where a patient apparently felt intimidated by her doctor and deliberately gave him false information about her condition: the doctor asked the patient, "You are drinking a lot of milk, aren't you?," to which the patient replied, "Oh, yes, I drink a lot of milk." Later, however, when the patient was asked the same question by a nurse, the patient admitted that since she hated milk, she never drank it.(2) Dr. Shuy suggests that the patient lied to her doctor in response to the way in which the question was asked, but it is also quite probable that this patient, like many others, lied to her doctor basically because she didn't trust him.

My own experience working in the out-patient clinic of a large inner-city

hospital justifies my belief that many patients don't trust their doctors and, consequently, withhold information or lie about their condition and symptoms. There were countless incidents where patients confided in me about which drugs they really took, what their pains really felt like, or how they really sustained an injury, information which, perhaps because they felt it embarrassing or too personal, they chose to withhold from their doctors. Some patients return to the clinic with the same problem that was treated the week before but, because they suspect the same symptoms will yield the same unsatisfactory treatment, this time, hoping their problem will be evaluated and treated more effectively, the same symptoms are exaggerated or different symptoms feigned. This may be a dismal commentary on the viability of inner-city clinics in general; however, it also indicates a more specific problem: when a patient feels he must adopt such strategic means to obtain satisfactory health care, it inherently evinces the patient's lack of confidence in the clinic doctor's professional competence, his ability to deal with the true symptoms of the patient's illness in an effective manner.

Unless a certain degree of openness and honesty can be established in the doctor-patient relationship, the medical interview fails to be an accurate guide to the doctor's evaluation and treatment of the patient's problem. The only way such openness and honesty can be established is, first, by inspiring in the patient a certain degree of confidence in the doctor's ability to correctly evaluate the patient's true symptoms and to prescribe effective treatment based on his evaluation; second, a certain degree of trust must also be inspired in the patient so that he won't be intimidated by the doctor to the point that he defensively withholds useful information about his condition. Naturally, if there is any hope of achieving these goals, more communication is prerequisite:

as ineffective communication between clinic doctors and clinic patients tends to result in ineffective health care, so the unsatisfactory health care provided by many inner-city clinics can be viewed partially as the unfortunate result of doctor-patient communication failure.

DOCTOR-PATIENT COMMUNICATION FAILURE: CONTRIBUTING FACTORS

The factors which interfere with effective communication between clinic doctors and their patients can be identified. According to Dr. Shuy, "communication between patient and doctor begins with a tremendous handicap--that of a supercharged state of emotion which color's the patient's perception of what the doctor is trying to say."(3) Dr. Shuy also cites another contributor to the communication breakdown: the physician's 'specialized professional vocabulary'. When he administered a questionnaire to a sample of 105 clinic patients at Georgetown University Hospital, Shuy found that 45 percent of the patients responded that they sometimes felt the doctor didn't understand the patient's problem, 38 percent thought the doctors and other medical personnel sometimes used words that were difficult to understand, 45 percent of the patients thought it was sometimes difficult for the patient to explain his problem to the doctor, and 35 percent said they thought doctors should speak in simpler language.(4) Moreover, Shuy suspects that conducting the survey in clinic waiting rooms probably created a setting that intimidated some patients into denying communication failure; this would mean that even though approximately half the respondents to Shuy's questionnaire indicated some sort of communication breakdown during the medical interview, the problem is probably more wide-spread than reported. C.P.Kimball, in his report on medicine and dialects, describes how the use of medical jargon inhibits communication between the doctor and patient, while they both fail to recognize any miscommunication:

> The Physician speaks a strange and often unintelligible dialect. He calls everyday common objects by absurd and antiquated terms. He speaks of mitral commissurotomies, pituitary insufficiency, and reality feed-back. This world is peopled by green-sticks, and hebephrenics. The professional dialect creates a communication gab between physician and patient that is generally acknowledged by neither. Not only does the physician speak a strange dialect, but more often than not he fails to recognize the dialects of his patients. (5)

Kimball also identifies a third factor which interferes with effective doctor-patient communication, "that medicine as a profession is a distinctly middle-class phenomenon." Because of the power, prestige, and financial security offered by the medical profession, most of its manpower is attracted from the middle class, and from the upper middle class especially. It follows that most doctors display life-styles, thought processes, and a dialect far removed from those of most clinic patients.(6) Regarding this class contrast between doctors and their patients, Shuy views the experience of minority group patients with the medical profession and that of minority group students with the teaching profession analogous:

> Much has been said about compensatory education in recent years. In reality, what this means is that the institution (the school) does not feel that certain minority group children are culturally, socially, or linguistically ready for education. To make them ready, a program is devised that will change their culture, social behavior and language to conform to the expectations of the school. Compensatory education argues essentially that the child must be like the school in order for the school to be able to teach him....Current medical practise utilizes a similar communication mode. The patient must adjust to the language and culture of the physician....The medical profession does no better job of starting with the patient <u>where he is</u> than does the teaching profession.... A great deal of miscommunication is currently taking place not simply because of the emotionally charged nature of the interaction, not simply because of the doctor's inconsiderate use of medical jargon, but because of a critical lack of aware-

> ness concerning the linguistic and cultural systems which some patients bring with them to their first meeting with the person to whom they intrust their health.(7)

Patient emotion, medical jargon, and the class contrast between the clinic doctor and the working class clinic patient--these are three factors which tend to inhibit effective doctor-patient communication in the clinic situation. The problem is a large one, worthy of much more consideration and research. In the interest of further study a fourth factor contributing to doctor-patient communication failure is proposed, namely the attitude which the patient develops toward the clinic doctor.

The sensitive doctor, understanding and appreciating the significance of the patient's trust and confidence in him, may make a conscious effort to help the patient feel comfortable. He may try to make sure that the patient is well informed about the implications of his particular problem, he may be careful to use words and phrases that the patient will fully understand when referring to his condition, he may be especially respectful, polite or friendly, but these efforts can only achieve so much to foster a more positive attitude in the patient. This is because certain elements of the patient's attitude toward his doctor are automatically formulated as soon as the patient hears the doctor speak. As the doctor introduces himself or begins to ask the questions of the medical interview, the patient may be making positive or negative judgements about the doctor's personality, his professional competence, and his trustworthiness depending on the doctor's dialect, expecially the way he pronounces the words he speaks. In such a case, regardless of the doctor's active attempts to inspire a doctor-patient relationship based on mutual honesty, understanding, and the

patient's confidence in his doctor's medical ability, automatic negative prejudgements of the doctor may still occur. David Abercrombe, in his article "The Social Basis of Language," explains the phenomenon this way:

> When a person speaks, a listener interprets what he says as, simultaneously, two quite different and separate systems of signs. An utterance consists of symbols referring to whatever is being talked about; but it is also at the same time an index to various things about the speaker, particularly his personality. These two systems of signs are quite independent of each other. In a similar way things such as gait, or the wearing of clothes, can, in addition to their main function, reveal personality; but probably no aspect of human behavior does this so constantly or so subtly as speech. It is especially the least conscious part of talking--pronunciation, general handling of the voice, gesture--which are the vehicles of these clues to personality. Almost everyone, when meeting a stranger, bases an immediate judgement on the way he or she talks, and...it is not always easy to say how present to consciousness these interpretations are. Sometimes it is only on careful reflection that an attitude taken up towards someone can be traced to his voice and pronunciation; at other times we are fully conscious of the effects of someone's voice on us.(8)

DIALECT AND AFFECTIVE RESPONSE

Many studies have been conducted examining the phenomenon of character, personality and credibility judgement based solely on dialect variation. In one such study, conducted by Roger Shuy and Frederick Williams in Detroit, a selected group or people were asked to evaluate five different English dialects: Detroit Speech, White Southern Speech, British Speech, Negro Speech and Standard Speech.(9) The evaluations were recorded on twelve semantic differential scales that Shuy and Williams felt reflected the connotative dimensions of judgement significant to speech attitudes. The respondents recorded how they reacted to the various dialect types by indicating within a seven-position

range the descriptive associations they made with each dialect: dull to sharp, smart to dumb, weak to strong, fast to slow, complex to simple, worthless to valuable, good to bad, thin to thick, careful to sloppy, rough to smooth, positive to negative, and difficult to easy. Shuy and Williams used the respondents ratings along these twelve scales to analyze the underlying dimensions of affective response: Value, Complexity, Potency and Activity. As expected, once the data was coordinated and analyzed, the results indicated a number of generalizations about how different people are affected by different dialects. For example, the study indicated that "blacks generally evaluate Negro Speech in a more positive manner than do white respondents," and, conversely, "black respondents generally rate Negro Speech as somewhat less complex" than the other dialect varieties.(10) The findings of the Shuy-Williams study also indicated that whereas black respondents generally rated Negro Speech more positively than the white respondents did, the white respondents, on the other hand, rated Standard Speech and Southern White Speech more favorably than did the black respondents. Of particular interest to this report, respondents of the two lowest socio-economic classes, the upper and lower working classes, gave the most positive Potency ratings to Negro Speech, the factors of the Potency dimension being strong to weak, sharp to dull, and simple to complex. Regarding the implications of their findings, Shuy and Williams concluded:

> That the different speech types were reliably and interpretably differentiated along these four dimensions (Value, Complexity, Potency, and Activity), is evidence that the dimensions reflect some level of psychological reality of stereotype attitudes of the respondents. These stereotype attitudes may be the other side of the social dialect coin in the sense that just as we may objectively classify the speech types assessed in this study, we may also expect to find persons' attitudes similarly differentiated among these types. In other words, dialect may have an objective reality in the way people talk, but it seems quite

> clear that it at the same time has a subjective reality in the kinds of consistent attitudes which people hold toward one another's speech.(11)

Wallace E. Lambert and G. Richard Tucker conducted a similar experiment, this time implementing a more specific set of judgement criteria based on the traits important for friendship and success. The subjects of their experiment listened to tape recorded speech samples representing speakers of six different English dialects: Network English (the typical mode of speaking of national newscasters), College-Educated White Southern Speech, College-Educated Negro Southern Speech, the dialect of College-Educated Negro Speakers from Mississippi presently attending Howard University in Washington, D.C., the dialect of Southern Negro Speakers, referred to as the Mississippi Peer Group, a dialect similar to that used by most students at the black college where the actual testing took place, and the dialect of alumni from this college who had since lived in New York City for several years, referred to as New York Alumni.(12) On a bipolar rating scale similar to the one used by Shuy and Williams the subjects rated each dialect speaker on his upbringing, intelligence, friendliness, disposition, education, speaking ability, trustworthiness, ambition, faith-in-God, talent, character, determination, honesty, personality, and consideration.(13)

The analysis of the judgement data demonstrated, as in the Shuy-Williams experiment, that the subjects were able to make reliable, clear differentiations of the various dialects. The findings indicated that both the black and the white listeners evaluated Network Speakers most favorable in comparison to the other five dialect speakers.(14) Also, black subjects rated the College-Educated White Southern Speakers least favorably in each of the fifteen traits, while white subjects judged the Mississippi Peer Group the least favorable dialect

speakers. Concerning the diverse perspectives of the black subjects and the white subjects as they rated the least favorable dialect, Lambert and Tucker summarized:

> These differences in views likely reflect basic comparisons in affectively-toned attitudes that representatives of America's major ethnic groups hold toward one another. The contrasts also make it evident that speech styles which are pleasing to one social group will not necessarily be so perceived by another.(15)

THE EXPERIMENT: DESIGN AND PROCEDURE

The present experiment was designed to determine whether or not the inner-city clinic patient tends to make subjective assessments of his doctor's personality, professional competence, and trustworthiness based on the doctor's dialect; and, if so, what type of dialect stimulates the most positive assessment of personality, competence, and trustworthiness, and is perceived most favorably by this type of patient.

The experiment entailed having clinic patients make subjective judgements about three different doctors in response to three tape recorded stimulus messages, each representing a dialect type. A total of nineteen variables, representing the traits of personality, competence, and trustworthiness, were to be evaluated based solely on the affective responses stimulated by each dialect type, and these judgements were to be translated on a bipolar differential rating scale with a 1 to 5 range. For Personality the variables were intelligence, friendliness, disposition, ambition, consideration for others, plus a 'general personality variable'. Competence evaluations were assessed by rating education, training, experience, expertise, carefulness, the ability to communicate, self-confidence, and a 'general competence variable'. Trustworthiness was to be determined by the patients' ratings of the variables fairness, ability to tell the

truth (honesty), kindness, sensitivity, and a 'general trustworthiness variable.'

Although several of the variables had been used in other experiments of this type, the variables and rating scale described above were designed especially for this experiment. The 'general variables' for personality, competence, and trustworthiness were incorporated as 'reference checks'. It is understood that the experimental design presumes a certain set of variables represents personality, competence, or trustworthiness, and the composite rating of variables of each set should represent an indirect assessment of each of the three features in question. The reference check was to be used this way: if, in response to hearing a stimulus message, a subject rated the general trustworthiness variable, say, relatively high (a rating of 4 or 5) but rated the variables fairness, ability to tell the truth, kindness, and sensitivity consistently low (ratings of 1 or 2), then it would follow that the list of variables did not adequately represent trustworthiness according to that subjects frame of reference, and the subject's judgement of the other variables of the trustworthiness category probably would not reflect his subjective assessment of the amount of trust inspired by the dialect type. If such discrepencies were discovered, the subject's judgements were not to be incorporated into this study; but minor discrepencies, those within a range of one rating point, were tolerated. The dialect types to be evaluated were labelled, for the purposes of data analysis and the ensuing discussion alone, Local-White, Local-Black, and Foreign. However, while the judgement data was being collected, the dialect types were distinguished only according to how each dialect speaker identified himself in the tape recorded stimulus messages, Dr. Sternbach, Dr. Bee, and Dr. Hadi respectively.(16)

The three doctors who spoke in the stimulus messages were all asked to pre-

tend to give aftercare instructions to a patient suffering from low back strain. A standardized instruction sheet, listing seven items of instruction, was provided for each doctor as a guide to avoid as much as possible a divergence in the content of the messages while simultaneously encouraging an extemporaneous tonal quality. Also, in the further interest of a realistic simulation, all three doctors had previous experience, and were presently, working in an outpatient clinic; since giving aftercare instructions to clinic patients was a part of their daily routine, they were relatively comfortable with the improvisation. The resulting stimulus messages were very similar in content, but exhibited significant contrasts in pronunciations, grammatical structures, syntactical structures, and paralinguistic speech styles. The three stimulus messages were recorded, the Local-White dialect first, followed by the Local-Black dialect, with the Foreign dialect last, to be played for a sample of clinic patients. The patients would then be asked to evaluate each speaker for the variables of Personality, Competence, and Trustworthiness by translating their affective responses onto the five-position bipolar differential rating scale.

The experiment was conducted as outlined in the Ambulatory Clinic waiting room of Billings Emergency Room (of the University of Chicago Hospitals and Clinics). The Ambulatory Clinic was chosen as the site of the experiment for two principle reasons: first, the patients triaged to the Ambulatory Clinic of the emergency room are usually not so ill as to be disturbed by the data-gathering activities of the survey, and many even seemed pleased to be able to occupy their waiting time by participating in the experiment; second, since the waiting room was comparatively small and set off from the larger, open "waiting area" of the Emergency Clinic, the size and location was ideal for interviewing anywhere from one to six subjects at a time without interruptions or intimidation from the many people outside who chose not to participate in the experiment. The relative privacy of

the waiting room also yielded a large amount of freedom to address the participants in the experiment as a group and to instill in the subjects a sense of responsibility for accurate data based on honest subjective response.

Patients triaged to the Ambulatory Clinic plus the friends and family members who were waiting for patients being treated in one of the two emergency room clinics constituted the judgement sample. Periodically the people in the Emergency Clinic waiting area were individually approached and asked if they would like to 'participate in a study on communication between doctors and patients;' those that agreed to be subjects in the experiment were directed to the Ambulatory Clinic waiting room, and those that refused were not asked again.

The experiment was most often conducted with small groups of subjects, generally consisting of two to four people. The rating instrument was distributed to the subjects once their first-hand familiarity with out-patient clinics had been established. They were informed that the speakers they would listen to were actual doctors, and that "what they (the doctors) say is basically the same, but how they say it is where they differ." The subjects were also assured that there were no 'right answers', that their personal, subjective responses only were being sought, and that their names would not be used or needed for the study. Time was then allowed to answer questions and to clarify any misunderstandings, and once all the subjects fully understood what was required of them, the tape recorded stimulus messages were played. The tape was stopped at the end of the first doctor's message so that the subjects in the group could finish rating his personality, competence, and trustworthiness as they perceived it. When all the subjects had finished, the second doctor's message was played. The subjects listened to and rated the third doctor only after the entire group had finished rating the second doctor. There were no references made to "dialect" or "accent"

variation until after the survey was completed by all the subjects, and then only in response to questions about the (generally racial) identities of the doctors heard on the recording and about the purpose of the study.

THE EXPERIMENT: RESULTS

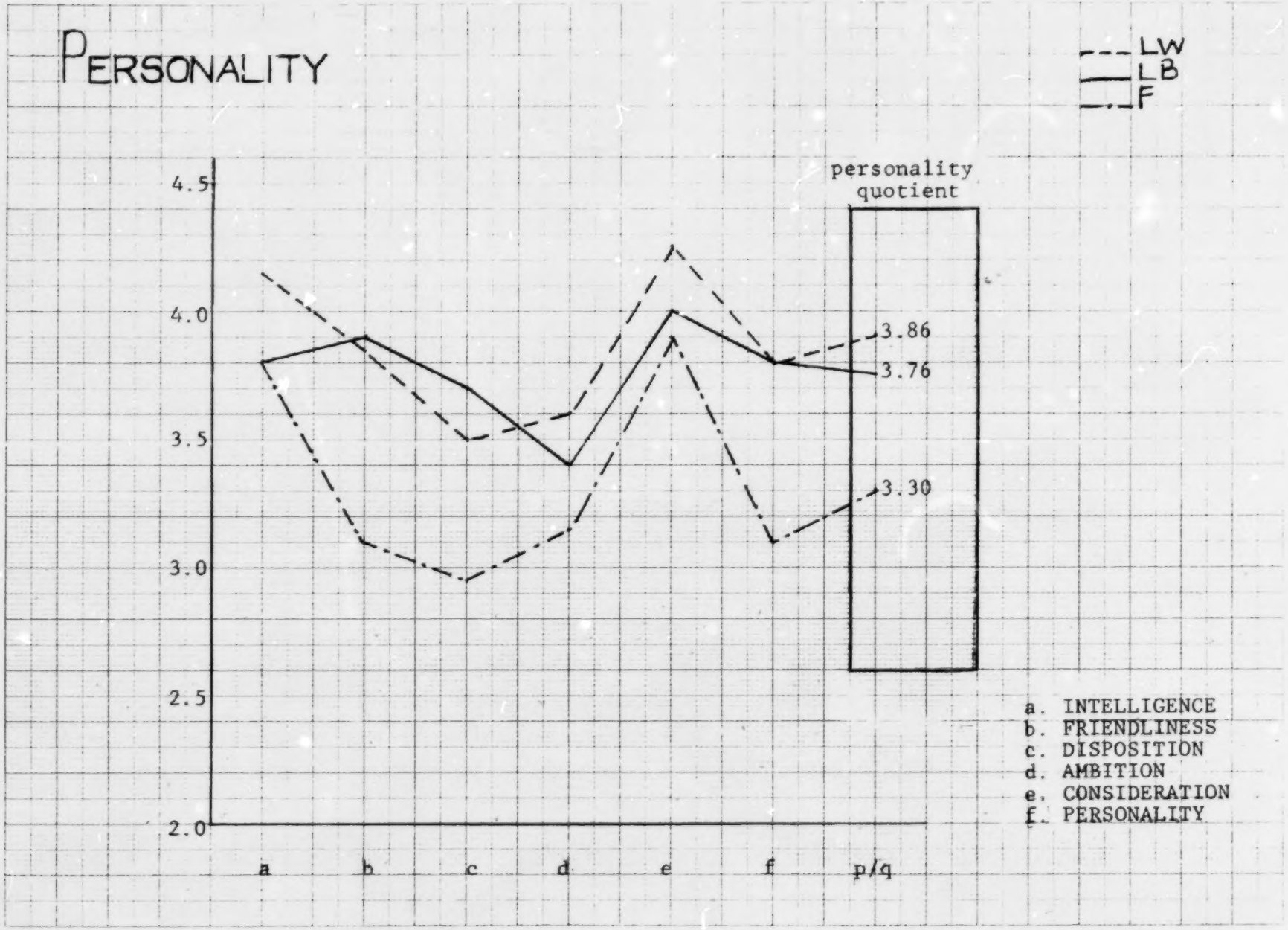
The final judgement sample consisted of twenty black subjects, and the mean ratings of the personality, competence and trustworthiness variables, based on their affective responses to the three stimulus messages, have been computed and are tabulated below:

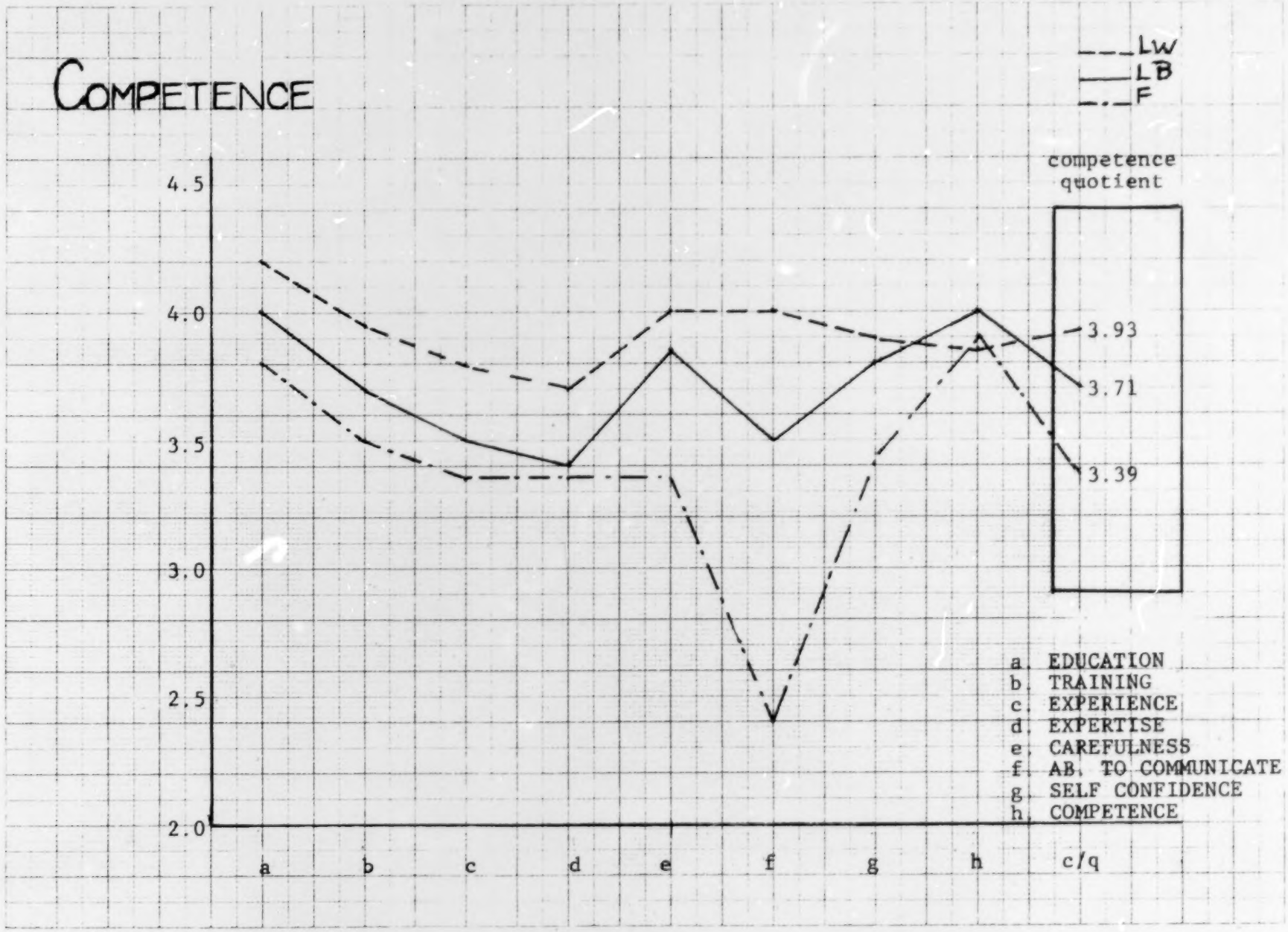
	LOCAL-WHITE	LOCAL-BLACK	FOREIGN
I. PERSONALITY			
(a) intelligence	4.15	3.80	3.80
(b) friendliness	3.85	3.90	3.10
(c) disposition	3.50	3.70	2.95
(d) ambition	3.60	3.40	3.15
(e) consideration for others	4.25	4.00	3.90
(f) personality	3.80	3.80	3.10
II. COMPETENCE			
(a) education	4.20	4.00	3.80
(b) training	3.95	3.70	3.50
(c) experience	3.80	3.50	3.35
(d) expertise	3.70	3.40	3.35
(e) carefulness	4.00	3.85	3.35
(f) ability to communicate	4.00	3.50	2.40
(g) self-confidence	3.90	3.80	3.45
(h) competence	3.85	4.00	3.90

	LOCAL-WHITE	LOCAL-BLACK	FOREIGN
III. TRUSTWORTHINESS			
(a) fairness	4.20	4.10	3.80
(b) ability to tell the truth	4.30	4.05	3.75
(c) kindness	4.00	3.90	3.65
(d) sensitivity	3.90	3.75	3.15
(e) trustworthiness	3.95	3.85	3.55

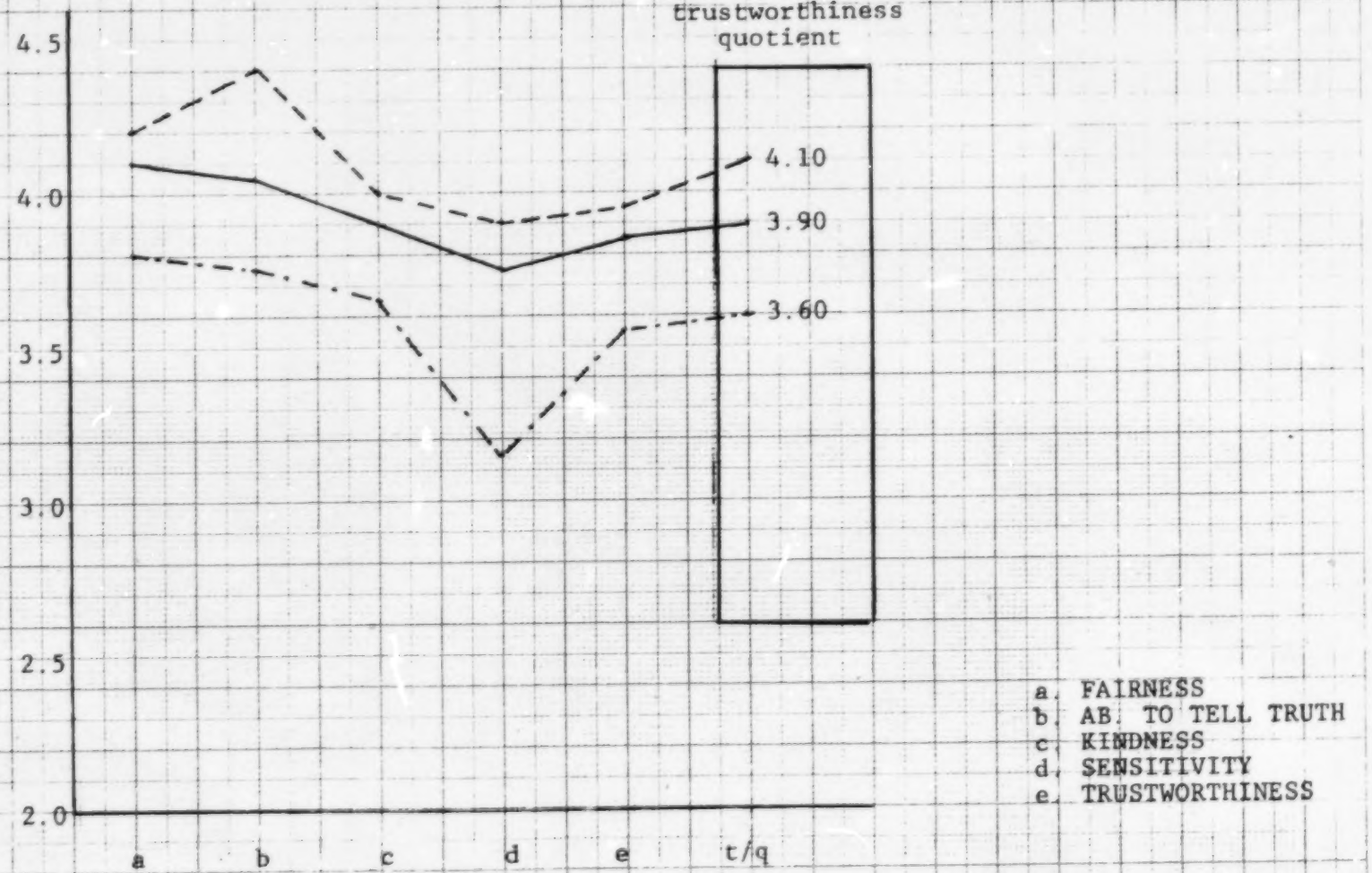
Graphing the mean ratings of the variables for each of the three categories (Personality, Competence, and Trustworthiness) according to dialect type most conveniently illustrates how the variance of the means correlates with dialect variation. The discussion of the data generates from this perspective of analysis. The variables for Personality, Competence, and Trustworthiness are indicated by letter along the horizontal axis of the appropriate graph: the right-most factor along the horizontal axis of each graph is designated p/q, c/q, or t/q, which stands for personality quotients, competence quotient, or trustworthiness quotient respectively. These "quotient" factors were achieved by computing the mean of the mean ratings of all the variables of each category; thus the quotients numerically represent the theoretical function of the general variable for each category. In the discussion of the graphs to follow the three dialect types will be abbreviated so that Local-White will be L-W, Local-Black will be L-B, and Foreign will be F.

PERSONALITY




COMPETENCE
LW
LB
F
competence quotient
4.5
4.0
3.5
3.0
2.5
2.0
3.93
3.71
3.39
a. EDUCATION
b. TRAINING
c. EXPERIENCE
d. EXPERTISE
e. CAREFULNESS
f. AB. TO COMMUNICATE
g. SELF CONFIDENCE
h. COMPETENCE
a
b
c
d
e
f
g
h
c/q

TRUSTWORTHINESS



a. FAIRNESS
b. AB. TO TELL TRUTH
c. KINDNESS
d. SENSITIVITY
e. TRUSTWORTHINESS

The PERSONALITY Graph

Whereas the speakers of L-B and F were indirectly assessed equally intelligent, L-W stimulated the most positive responses for the intelligence variable of all three dialect types. L-W was also perceived to show the most ambition and consideration for others, and in each case was closely followed by L-B (yielding a margin of .20 to .25 rating point) and F (yielding the large .45 rating point margin for ambition and .35 rating point margin for consideration for others). It should be noted that although the mean ratings for the 'general personality variable' were equal for L-W and L-B, the personality quotient (p/q) for L-W exceeds that for L-B by .10 rating point. This might suggest that the subjects considered friendliness and disposition, the only two variables for which L-B outranked L-W in the personality category, of more significance to an assessment of personality than ambition and consideration for others, and, when judging the L-B speaker, responded more positively for the 'general personality variable' than the responses to variables I.a. through I.e. would predict, but still reflecting subjective personality judgement nonetheless.

The COMPETENCE Graph

As expected, F was assigned an extremely low assessment by the respondents for the variable 'ability to communicate' (yielding a margin of 1.6 rating points to the high 4.0 rating achieved by L-W). The mean ratings for F were consistently the lowest for all of the variables of this category with one exception--the 'general competence variable'. Conversely, L-W maintained the high mean for all the variables except one, where it took the low position on the graph--the 'general competence variable'. For this variable F exceeded L-W by .05 rating point in spite of the fact that F's consistent low position up to this point creates a margin averaging .62 rating point. Similarly, L-B's mean ratings were consistently lower than those of L-W, generating an average margin of .26 rating point for the variables II.a. through II.g.; for the 'general competence variable', the 'h' factor on the graph, the mean rating of L-B exceeds that of L-W by .15 rating point. With L-W achieving the high mean (3.93), L-B following .22 rating point below L-W (3.71) and F achieving the low mean (3.39) at .54 rating point below L-W, the competence quotient (c/q) reestablishes the trend.

The TRUSTWORTHINESS Graph

The subjects rated L-W as the dialect type of the three that stimulated the most positive responses to all the variables in the category. L-B followed, maintaining the middle position on the graph throughout the entire category and, likewise, F kept the lowest mean rating throughout, taking an especially low position on the graph for the sensitivity variable, the 'd' factor. The data relating to this category most strongly suggests a correlation between dialect variation and affective judgement.

Based on the results of the experiment the generalization can be made that the Local-White dialect was perceived the most favorable of the three dialect types in all three categories. This preference is particularly illustrated by the high personality quotient, competence quotient, and trustworthiness quotient achieved by the Local-White dialect speaker. The establishment of such a trend offers enough implications for volumes of interpretation, especially since all the respondents of the judgment sample were black; but given an all-black sample's predominant overall assessment of Local-White speech, two basic questions should be addressed in terms of a primary interpretation of the results of the experiment: first, noting only three exceptions, why did the sample consistently indicate a more positive attitude toward Local-White speech for all the variables of the judgment instrument, and second, why were the three variables for which the Local-White dialect did not achieve the highest mean rating perceived differently from the other sixteen judgment variables?

INTERPRETATION: THE STEROTYPIC PAIRING FUNCTION (FRASER)

The black respondents' general preference for the Local-White dialect could have been predicted based on the similar findings of the Lambert-Tucker study of dialect and affective response cited earlier. In this study "(the group labelled Network Speakers) was considered as most favorable of six dialect groups by the Negro judges and by the southern white judges on every trait, and by the northern white judges on 12 of the 15 traits."(17) Unfortunately, Lambert and Tucker don't advance any interpretation of these results which might be applicable to the findings of the present experiment. However, when Bruce Fraser conducted a modified version of Lambert and Tucker's experiment, he also obtained very similar results, plus evidence of the following phenomenon: "when the speaker was black, and when the subjects misjudged the race of the speaker, they tended, in general, to rate the

speaker lower in all categories....On the other hand, when the speaker was white and when the race of the speaker was misjudged, the subjects did not tend, in general, to rate the speaker lower than average."(18) Of the fifty students who were subjects of Fraser's experiment four were black, two of which filled out their evaluation forms so that they wouldn't influence the relative evaluations of the speakers made by the white students; so, for all practical purposes, Fraser's respondents could be considered a white judgment sample. Fraser explains the new findings of his experiment with the theory that every dialect group has a "stereotypic pairing function"...

> ...which maps each point on a scale called 'Manner of Speaking' (linguistic features such as pronunciation, syntactic form, choice of words, intonation, rate of speech, voice quality, and so forth) onto a scale for certain character traits, for example, those used in the experiment (see the traits evaluated in the Lambert-Tucker study)....Now assume that this pairing is race-dependent. That is, given a level of speech the pairing has one set of values for white speakers, for example, but another for black speakers. If, for a given manner of speaking this pairing showed higher values for blacks as opposed to white speakers, this would account for the data (which evidences the phenomenon). (19)

Even though Fraser's theory suggests "yet another form of covert racism," he believes the phenomenon isn't rare: "the simple fact is that people will judge differently on the basis of certain cues--in this case speech alone--because of their experience and certain, albeit inaccurate, stereotypes."(20)

Fraser's discovery sheds some light on the results of the present experiment. Both tne experimental designs and procedures were similar and, also, both judgment samples could practically be labelled either black or white. Just as Fraser's white respondents might have assigned higher values to their assessment of those speakers they presumed to be black, so the black respondents of the present study might have assessed more positively the dialect they identified as white. Such

stereotypic pairing of high intelligence, education, ambition, self-confidence, and the like with the Local-White dialect would account for that dialect receiving the highest mean ratings for sixteen of the nineteen judgment variables.

The operation of this "stereotypic pairing function" in the present experiment is even more conceivable and probable when the context of the represented speech event is considered: a doctor is giving instructions to a clinic patient. Since most medical professionals in this country are white, and since most inner-city doctors are white, it is quite possible that to the inner-city clinic patient "the clinic doctor" is a white entity, black and foreign doctors being thought of as the exceptions to the general rule. The media has advanced Dr. Kildare, Dr. Ben Casey, and Dr. Marcus Welby as the national image of "the doctor," with no prime-time exposure afforded either a black or a foreign optional image. Consequently, the acculturation of the clinic patient subliminally impresses "the doctor" into his consciousness, and, like Kildare, Casey, Welby, and others, "the doctor" is trustworthy, competent, friendly, intelligent, considerate of others, and white as well. The black respondents might have simply had a more positive attitude toward the dialect they perceived to represent the most likely candidate for the hypothetical situation established by the experimental design.

INTERPRETATION: THE EFFECT OF NON-FLUENCY VARIATION (MILLER-HEWGILL)

Another possible reason for the predominant mean rating of the Local-White dialect speaker is based on results of a study conducted by Gerald H. Miller and Murray A. Hewgill on the effect of non-fluency variation on audience ratings of competence, trustworthiness, and dynamism.(21) Miller and Hewgill tape recorded nine versions of a message, each version differing only in the number of non-fluencies contained within the message. The experiment used two types of

non-fluency: a vocalized pause, or the utterance of "uh" (phonetically [ə] to [ʌ] between two words of the message, and a repetition, or the utterance of the first syllable of a word, followed by the utterance of a short "uh" sound (phonetically [ə], followed by the utterance of the complete word. Subjects, after hearing a version of the message, rated the speaker on a seven-position semantic differential scale for the factors of Competence (experienced to inexperienced, expert to ignorant, trained to untrained, and competent to incompetent), Trustworthiness (just to unjust, kind to cruel, admirable to contemptible, and honest to dishonest), and Dynamism (agressive to meek, bold to timid, energetic to tired, and extroverted to introverted). The results of the experiment indicated a consistent reduction of source credibility for the competence and dynamism factors, though a somewhat less conclusive reduction for the Trustworthiness factors. In any event, Miller and Hewgill concluded that "generally, it appears that as the quantity of non-fluency presented by the speaker increases, audience ratings of perceived source credibility decrease."(22)

The tape recorded messages used in the present experiment had very few occurrences of a repetition non-fluency, but vocalized pauses occurred in each dialect message in quantities significant enough to correlate with the mean personality, competence, and trustworthiness variable ratings in a general way. The Local-White dialect message was 95 seconds long and had 4 vocalized pauses, averaging approximately one non-fluency per 24 seconds (23); the Local-Black dialect message was somewhat longer, 150 seconds, with 14 vocalized pauses and an average of about one non-fluency every 11 seconds; the Foreign dialect message lasted 110 seconds and had 12 vocalized pauses, averaging approximately one non-fluency per 9 seconds. As in the Miller-Hewgill study, as the frequency of vocalized pauses increased within each message, so the mean ratings in almost all the judgment variables decreased. This observation is not meant to interpret the mean ratings as a function of the non-fluency frequency in each dialect, but

merely to suggest that the correlation exists. Miller and Hewgill considered their experiment only the beginning of research of vocal cues that affect audience reactions to a speaker and, likewise, the correlation observed cannot be considered conclusive evidence of any general trend, but merely serve as a directive for further investigation and a possible explanation for the trends established by the black judgment sample of the present experiment. The Local-White dialect message had the lowest non-fluency frequency and was generally rated highest of the three dialect types; the Foreign dialect message had the highest non-fluency frequency and was generally rated lowest; the Local-Black dialect message had a lower non-fluency frequency than the Foreign dialect message, but a higher non-fluency frequency than the Local-White dialect message--it was generally rated higher than the Foreign dialect, but lower than the Local-White dialect.

INTERPRETATION: ANOMALIES IN THE TREND

The trend generated by the mean ratings of the judgment variables had three anomalies: in the Personality category, the mean rating for the friendliness variable (I.b.) and that for the disposition variable (I.d.), and in the Competence category, the mean rating for the 'general competence variable' (II.h.). To begin with, although the Local-White dialect was generally perceived the most favorable of the three, for friendliness and disposition the most positive mean rating was achieved by the Local-Black dialect. This divergence from the general trend poses the question: why was the Local-Black dialect perceived more positive than the Local-White dialect for these two variables?

One plausible answer is based on the subjects' inevitable racial and cultural identification with the speaker of the Local-Black dialect. Roger Abrahams, in his discussion of Black English, says:

> BE is not just a linguistic system; it is an expressive system of Black Culture. This system includes not only linguistic features, but also the numerous paralinguistic traits which are recognizably characteristic of black speech (elongation of words or raising pitch level for emphasis, use of a wide range of vocal effects from falsetto to false bass to growl, unexpected syllables or words, and so on....BE has maintained itself because of its adaptability in a situation in which flexibility means ability to contend and endure; and more specifically, the use of BE provides an on-going and vital cohesive devise, recognizable as characteristically black.(24)

The subjects' identification with the speaker of the Local-Black dialect could largely account for the favorable response recorded for the friendliness and disposition variables. Why wasn't that same favorable response extended to the other variables of the Personality category, especially since the speaker was perceived to share the same racial and similar cultural identifications with the respondents of the judgment sample? It is most likely that the sample's ratings for the intelligence and ambition variables of the category were probably influenced by society's stigmatization of non-standard dialects of English. With the recent exception of enlightened students and professors of sociolinguistics, most of the educated and educators in this country traditionally stereotype speakers of non-standard dialects as having inadequate educational backgrounds, below average IQ's, and little motivation and potential for upward mobility within the established social strata. In the policies and programs of our educational systems and in the reflection of our society projected by the mass media the stereotypes still prevail. These generally accepted stereotypic associations of non-standard speech with relatively low intelligence and ambition are undoubtedly accepted by most members of the working class. For many, mastery of standard English usage is considered one of the keys to a better job, a higher income bracket, an elevated socioeconomic status. This faith in the power of 'proper English' cues to an

acceptance of the traditional stereotype of the non-standard English speaker, and the sample's acceptance of that stereotype could account for their relatively low assessment of the Local-Black dialect speaker's intelligence and ambition. An interesting test of this hypothesis would be to have working class subjects rate the same three speakers on their perceived "street-knowledge"--the responses would probably be most positive for the Local-Black dialect speaker, most negative for the Foreign dialect speaker, with the Local-White dialect stimulating responses somewhere between these two extremes. Certainly this is conjecture but, given the hypothetical situation, the hypothetical results would be as much a function of racial stereotyping as the sample's intelligence and ambition assessments appear to be.

Another anomaly is found in the mean rating achieved by the general competence variable. Even though the most positive mean ratings for Competence variables II.a. through II.g. are consistently achieved by the Local-White dialect speaker, the most negative mean ratings are consistently achieved by the Foreign dialect speaker, and the Local-Black dialect speaker is consistently rated somewhere in between, this apparently reliable trend takes an unexpected turn for variable II.h., the general competence variable--the mean ratings indicate that the Local-Black dialect speaker is perceived the most competent, the Foreign dialect speaker is perceived the next in line, and the Local-White dialect speaker is perceived the least competent of the three. There seems to be no way to account for such results unless it is assumed that the judgment variables didn't accurately represent the dimensions of competence as the term was understood by the respondents. This possibility is recognized, though not readily accepted by the present writer as a valid interpretation of the anomaly; but the possibility must be noted here for lack of a better explanation of the surprising results.

THE BLACK JUDGMENT SAMPLE AND ACCULTURATED RESPONSE

Although the data of the present experiment empirically proves that of the three dialect types represented by the stimulus messages the most favorable responses were generally stimulated by the Local-White dialect, the strength of the evidence alone won't support any conclusive statements regarding the significance of this finding. Any conclusions of this type would prove very dangerous since biases based on widely accepted stereotypes, biases which influenced the respondents' subjective assessments of the different dialect speakers, cannot be adequately discussed, or the extent of their influence estimated, at this time. Perhaps this limitation holds true for any empirical evidence of affective response and, therefore, should be taken for granted when generalizations are made based on empirical data. However, information concerning socialized or acculturated response should be considered essential to any valid interpretation of empirical data obtained from the subjective evaluations of a racially homogeneous judgment sample.

When the racially homogeneous judgment sample happens to be black, the implications of socialization are intensified. St. Clair Drake illuminates the problem that emerges for many blacks in the face of the socialization inherent in their exposure to the schools and the mass media of this country--the identification problem:

> The White Middle Class is the reference group for those who are mobile; yet the entire system operates to emphasize identity with "The Race," since defensive solidarity must be maintained against the white world....Negroes in America, as a numerical minority, always have a feeling of being "on the outside looking in," of not being in the main stream." Yet, the mere fact of being only one in ten does not automatically generate this feeling; the "victimization" flows

> rather, from the values of the majority who refuse to accept every individual upon his own merit, but insists upon ascription of status on the basis of membership in a racial group.... A Negro child seldom sees a person like himself in an advertisement or in illustrations accompanying fiction. The children in the textbooks are all white. The image of the powerful, the desirable, the admirable is set very early as "white."...This isolation not only generates distorted perceptions of the total society and occasionally bizarre definitions of situations, but it also results in cognitive crippling. The communication flow needed to provide data for rational decision making is often impeded. Incomplete information is available for "playing the game" the way it is played in various segments of the larger society, and in a highly mobile society it is all important to know "who is who" and "what is what."(25)

Although some effort has been made to represent blacks in textbooks and in the media within the last ten years, there is no question that the atmosphere Drake describes predominated the era in which the respondents of the judgment sample grew up, and still pervades much in much of American culture today. So, to develop a valid interpretation of the data, one must consider just how the judgments made by the black sample reflected this identification problem. Unfortunately, there's no way to tell. This report attempts to present some plausible explanations for much of the data, but they are presented only as possibilities, probabilities, conjecture, and the opinion of the present writer, not presuming to make conclusive, sociologically significant interpretations of the data yielded by the experiment--no valid generalizations of this type can be made based on the empirical evidence alone.

But the evidence does support the generalization that inner-city clinic patients tend to make subjective assessments of the personality, professional competence, and trustworthiness of the clinic doctor based on the dialect of that doctor. In most cases the tendency of the sample exhibited a consistent preference for the

Local-White dialect speaker, with the Local-Black and Foreign dialect speakers being consistently rated second and third respectively. The trend is reliably maintained for the sample's assessments of sixteen out of nineteen judgment variables and, therefore, appears conclusive. So, although this report does not presume to interpret the significance of the established trend, it does empirically prove that such a trend was indeed clearly established based solely on the affective responses of the judgment sample to three stimulus messages fundamentally differing only in the dialects of the three doctors speaking.

CONCLUSION: CONSEQUENCES AND SUGGESTIONS

What are the consequences of these findings? Initially, the discoveries of this study and others like it warrant further investigation of miscommunication between clinic doctors and their patients. Whereas Shuy and Kimball isolate three contributions to doctor-patient communication breakdown (patient emotion, medical jargon, and the class contrast between the middle class doctor and the working class patient), and the present study isolates a fourth (the attitude the patient formulates toward the doctor based on his dialect), conceivably there may be countless other contributors to the problem which have yet to be discovered. Through further inquiry and investigation many, if not all, of these potential communications barriers can be identified so that measures can be taken to neutralize their negative effects, or to compensate for them in some way, or perhaps even to extinguish their influence as contributors to communication failure. When the diverse elements of the problem are accurately identified, only then can any expedient solution be instituted.

Until that time there are a number of measures that can be taken to alleviate the problem. To start, the clinic doctor should be made aware that doctor-patient

miscommunication is a very real problem, one that ultimately influences the effectiveness of clinical medicine. He should be reminded that whereas he may see fifteen patients in a day, generally the patient will only see one doctor; whereas the examination room may be familiar to him, the patient will generally feel less than comfortable in such unfamiliar and impersonal surroundings; whereas he may be able to speak openly and frankly about illness, the topic is not generally included in the patient's daily conversation; whereas he may take the meanings of many medical words and phrases for granted because doctors use them often, medicine is not the patient's specialty and medical jargon often clouds the layman's understanding; and whereas middle-class people tend to assume certain things basic to almost any lifestyle, like heat in the winter or at least one balanced meal a day or the recognition of the fallacy in folklore and old wive's tales, these assumptions can prove especially dangerous--even fatal--where medicine and health are concerned.

The doctor should also be made aware that his dialect, be it similar to or very different from that of his patient, plays an important role in how he is perceived by his patient, and the patient's perception of the doctor in many ways determines what information will be volunteered in the medical interview and what instructions the patient will follow. Recognizing the existence of communication barriers, the doctor should be observant for signs of communication breakdown--perhaps the pieces of the patient's story don't seem to fit together, suggesting something is being left out, or there is a discrepency between what the patient says about his condition and the patient's lab results, or perhaps the patient seems confused, or appears too eager to show he fully understands the implication of his illness. In cases like these, if the doctor suspects miscommunication, he should be encouraged to seek the assistance of someone who may be able to better relate to his patient: a Spanish-speaking patient who speaks English well as a second language may still be able to explain himself better in

Spanish-- he should be allowed, even encouraged, to discuss his condition with Spanish-speaking medical personnel who can then interpret the problem for the doctor; a woman may at first feel uneasy discussing a gynecological problem with a male clinic doctor--if this uneasiness is detected, the doctor should attempt to find someone who may make the experience less difficult for the patient and, consequently, more beneficial to the doctor and patient alike; if aftercare instructions are complicated, the doctor should ask the patient's permission to also explain them to the patient's spouse, roommate, or a member of the patient's family. The responsibility for controlling doctor-patient communication failure may fall most heavily on the shoulders of the clinic doctor, but his efforts to ensure more effective communication must be viewed simply as the practice of more effective clinical medicine, simply as part of the job.

Yet some responsibility for controlling doctor-patient miscommunication must also be assumed by the patient. He must be made aware that what seems obvious about his condition isn't necessarily apparent to the doctor simply because medicine is the doctor's profession; he must be encouraged to consider no detail of his problem too trivial to mention, no item of instruction too minor for clarification. The patient must also be encouraged to ask questions of his doctor, and not to be afraid or embarrassed to express confusion--the clinic patient must not consider his doctor too busy to satisfy him with clear, comprehensive information, explanations, and instructions. It may be the case that a communication barrier which is obvious to the patient will not be recognized by the clinic doctor; for the benefit of the patient and doctor alike, the patient must be urged to bring it promptly to the attention of his doctor or some other member of the clinic's staff before mistakes are made because of misunderstandings.

Clinic administrators too must share the burden of the communication problem.

They must be mindful that miscommunication between doctors and patients strongly influences the quality of treatment patients receive from the clinic. Elements of communication failure particular to individual clinics must be isolated and reconciled along with those identified in this and other independent reports. This is essential to dealing with miscommunication in inner-city clinics or clinics serving less culturally integrated communities. The dietary, social, and religious practices of one cultural community are often totally different from those of another cultural community, yet these things greatly affect health problems and the practical, culturally feasible treatment of those problems. For example, for a doctor to advise an inner-city, black, working class mother who is suffering from hypertension to avoid stress situations is culturally infeasible; the same advice might be all that's necessary to treat an upper-middle class suburban housewife who is suffering from the same problem. It is the responsibility of the clinic administrator to attempt to determine the extent of doctor-patient communication failure in the clinic, and to try to identify the contributors to the communication gap, especially those stemming from the class and cultural contrasts between the clinic doctors and their patients. He must ensure that measures are taken to alleviate the general contributions to the problem, and especially those particular to the individual clinic.

A solution to the problem of communication failure in the clinic will not be easily found, but everyone involved in any way with clinical medicine must take responsibility for controlling the menace by making conscious efforts toward improving the situation now. A clear understanding of the implications of the problem, and the cooperative attempt of clinic administrators, doctors, other medical personnel, and patients to at least minimize communication failure where it can't be immediately ended must begin now, before ineffective doctor-patient communication puts an end to effective clinical medicine.

FOOTNOTES

1. Herford, C.H., ed. Ben Jonson, Vol. VIII. (London: Oxford University Press, 1947), p. 625.

2. Shuy, Roger W. "The Medical Interview: Problems in Communication", Primary Care Vol. 3, No. 3 (September, 1976), p. 374.

3. Shuy, Roger W. "Sociolinguistics and the Medical History", a paper presented at the 3rd International Conference of Applied Linguistics (Copenhagen: August, 1972), p. 2.

4. Shuy, "The Medical Interview", p. 370.

5. Kimball, C.P. "Medicine and Dialects". Annals of Internal Medicine Vol. 74, No. 1 (January, 1971), pp. 137-138.

6. Ibid., p. 138.

7. Shuy, "Sociolinguistics and the Medical Interview", p. 5.

8. Abercrombie, David. "The Social Basis of Language", in Teaching Language as a Second Language, Harold B. Allen, ed. (New York: McGraw-Hill, 1965), p. 18.

9. Shuy, Roger W. and Williams, Frederick. "Stereotyped Attitudes of Selected English Dialect Communities", in Language Attitudes: Current Trends and Prospects, Roger W. Shuy and Ralph W. Fasold, eds. (Washington: Georgetown University Press, 1973), pp. 85-96.

10. Ibid., p. 90.

11. Ibid., p. 95.

12. Lambert, Wallace E. and Tucker, G. Richard. "White and Negro Listeners' Reactions to Various American English Dialects", in Perspectives on Black English, J.L. Dillard, ed. (The Hague: Mouton, 1975), pp. 369-377.

13. The bipolar rating scale was constructed upon the most popular responses of students from a small southern black college when they were asked which traits they considered important for friendship and success. Lambert and Tucker added the traits speaking ability and good upbringing to the list because they thought them appropriate to their study.

14. It should be noted here that all of the Network Speakers were white: Lambert and Tucker, p. 371.

15. Lambert, Wallace E. and Tucker, G. Richard, p. 377.

16. Dr. (George) Sternbach was raised in Detroit, Michigan and attended college and medical school in Michigan as well. He has lived in Chicago since 1973,

and has been involved in clinical medicine since 1972.
Dr. Kenneth Rivers, who identified himself as Dr. 'B' in the stimulus message, was raised on Chicago's South Side. He attended college and medical school in Chicago, and has been involved in clinical medicine since 1973.
Dr. Hadi (Hedayati) was raised in Iran. He attended college and medical school in Iran, where he also learned to speak English. From 1972 to 1973 he lived in Cleveland, Ohio and from 1973 to the present he has lived in Chicago. He has been involved in clinical medicine since 1970.

17. Lambert, Wallace E. and Tucker, G. Richard, p. 376.

18. Fraser, Bruce. "Some 'Unexpected' Reactions to Various American-English Dialects", in Language Attitudes: Current Trends and Prospects, Roger W. Shuy and Ralph W. Fasold, eds. (Washington: Georgetown University Press, 1973), (pp. 28-35) p. 32.

19. Ibid., pp. 32-33.

20. Ibid., p. 35.

21. Miller, Gerald A. and Hewgill, Murray A. "The Effect of Variations in Nonfluency on Audience Ratings of Source Credibility", in The Psychosociology of Language, Serge Moscovici, ed. (Chicago: Markham, 1972), pp. 417-430.

22. Ibid., p. 426.

23. It should be noted here that the first sixty seconds of the message were free of any vocalized pause nonfluency.

24. Abrahams, Roger D. "The Advantages of Black English", in Language, Society and Education: A Profile of Black English, Johanna S. DeStefano, (Worthington: Charles A. Jones, 1973), pp. 100, 105.

25. Drake, St. Claire. "The Social and Economic Status of the Negro in the United States", in Language, Society and Education: A Profile of Black English, Johanna S. DeStefano, ed. (Worthington: Charles A. Jones, 1973), pp. 86-87.